

Anthem Blue Cross and Blue Shield
Washington and Lee University Anthem KeyCare PPO

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 07/01/2014 - 06/30/2015

Coverage for: Individual/Family | Plan Type: PPO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-800-451-1527.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$250 Individual/ \$500 Family for In-Network Providers. \$200 Individual/ \$400 Family for Out-of-Network Providers.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$1,500 Individual/ \$3,000 Family for In-Network Providers. \$2,750 Individual/ \$5,500 Family for Out-of-Network Providers.	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Cost of Routine Vision Care, Premiums, Balance-billed charges and Health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See www.anthem.com or call 1-800-451-1527 for a list of In-Network Providers.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a specialist.	You can see the <u>specialist</u> you choose without permission from this plan.

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Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 8. See your policy or plan document for additional information about excluded services .
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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15 Copay/Visit	20% Coinsurance	-----none-----
	Specialist visit	\$40 Copay/Visit	20% Coinsurance	-----none-----
	Other practitioner office visit	<u>Chiropractor</u> \$15 or \$40 Copay <u>Acupuncturist</u> Not Covered	<u>Chiropractor</u> 20% Coinsurance <u>Acupuncturist</u> Not Covered	<u>Chiropractor</u> Coverage is limited to 30 visits per benefit year for Spinal Manipulation and Manual Medical Therapy Services combined In-Network Providers and Out-of-Network Providers. There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation. <u>Acupuncturist</u> -----none-----

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	Preventive care/screening/immunization	No Cost Share	20% Coinsurance	-----none-----
If you have a test	Diagnostic test (x-ray, blood work)	<u>Lab – Office</u> 0% Coinsurance <u>X-Ray – Office</u> \$20 Copay/Visit	<u>Lab – Office</u> 20% Coinsurance <u>X-Ray – Office</u> 20% Coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	\$100 Copay/Visit	20% Coinsurance	Your payment responsibility is waived if services are billed as part of an Emergency Room visit.

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<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at www.anthem.com</p>	Tier 1 - Typically Generic	<p>\$15 Copay/ Prescription for Retail Pharmacies</p> <p>\$15 Copay/ Prescription for Home Delivery</p>	Member pays 100% Cost Share	<p>30-day supply for Retail Pharmacies.</p> <p>90-day supply for Home Delivery.</p> <p>Out-of-Network: You pay the full cost of the drug, then submit a claim form for reimbursement.</p>
	Tier 2 - Typically Preferred/Formulary Brand	<p>10% of Drug cost with a minimum \$40 Copay; maximum \$100 Copay for Retail Pharmacies</p> <p>10% of Drug cost with a minimum \$80 Copay; maximum \$200 Copay for Home Delivery</p>	Member pays 100% Cost Share	<p>30-day supply for Retail Pharmacies.</p> <p>90-day supply for Home Delivery.</p> <p>If you or your doctor requests a Brand Name Drug when a Generic is available, you will pay your usual Copayment for the Generic Drug plus the difference in the allowable charge between the Generic and Brand name Drug.</p> <p>Out-of-Network: You pay the full cost of the drug, then submit a claim form for reimbursement.</p>
	Tier 3 - Typically Non-preferred/Non-formulary Drugs	<p>10% of Drug cost with a minimum \$60 Copay; maximum \$100 Copay for Retail Pharmacies</p> <p>10% of Drug cost with a minimum \$180 Copay; maximum \$300 Copay for Home Delivery</p>	Members pays 100% Cost Share	<p>30-day supply for Retail Pharmacies.</p> <p>90-day supply for Home Delivery.</p> <p>If you or your doctor requests a Brand Name Drug when a Generic is available, you will pay your usual Copayment for the Generic Drug plus the difference in the allowable charge between the Generic and Brand name Drug.</p> <p>Out-of-Network: You pay the full cost of the drug, then submit a claim form for reimbursement.</p>

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If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 Copay/Visit	20% Coinsurance	-----none-----
	Physician/surgeon fees	0% Coinsurance	20% Coinsurance	-----none-----
If you need immediate medical attention	Emergency room services	\$200 Copay/Visit	20% Coinsurance	Waived if admitted directly to the hospital.
	Emergency medical transportation	10% Coinsurance	10% Coinsurance	-----none-----
	Urgent care	\$15 or \$40 Copay	20% Coinsurance	There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200 Copay/Confinement	20% Coinsurance	You do not have to pay another Inpatient Copay if you are readmitted for the same or related condition within less than 90 days from when you went home.
	Physician/surgeon fee	0% Coinsurance	20% Coinsurance	-----none-----

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If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	<u>Mental/Behavioral Health Office Visit</u> \$15 Copay/Visit <u>Mental/Behavioral Health Facility Visit – Facility Charges</u> \$150 Copay/Visit	<u>Mental/Behavioral Health Office Visit</u> 20% Coinsurance <u>Mental/Behavioral Health Facility Visit – Facility Charges</u> 20% Coinsurance	-----none-----
	Mental/Behavioral health inpatient services	\$200 Copay/Confinement	20% Coinsurance	-----none-----
	Substance abuse disorder outpatient services	<u>Substance Abuse Office Visit</u> \$15 Copay/Visit <u>Substance Abuse Facility Visit – Facility Charges</u> \$150 Copay/Visit	<u>Substance Abuse Office Visit</u> 20% Coinsurance <u>Substance Abuse Facility Visit – Facility Charges</u> 20% Coinsurance	-----none-----
	Substance abuse disorder inpatient services	\$200 Copay/Confinement	20% Coinsurance	-----none-----
If you are pregnant	Prenatal and postnatal care	0% Coinsurance	20% Coinsurance	-----none-----
	Delivery and all inpatient services	\$200 Copay/Confinement	20% Coinsurance	Applies to inpatient facility. Other cost shares may apply depending on the services provided. You do not have to pay another Inpatient Copay if you are readmitted for the same or related condition within less than 90 days from when you went home.

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If you need help recovering or have other special health needs	Home health care	0% Coinsurance	20% Coinsurance	Coverage is limited to 100 visits per benefit year combined In-Network Providers and Out-of-Network Providers.
	Rehabilitation services	\$40 Copay/Visit	20% Coinsurance	There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation.
	Habilitation services	\$40 Copay/Visit	20% Coinsurance	Habilitation visits count towards your Rehabilitation limit.
	Skilled nursing care	0% Coinsurance	20% Coinsurance	Coverage is limited to 100 days for each admission combined In-Network Providers and Out-of-Network Providers.
	Durable medical equipment	10% Coinsurance	20% Coinsurance	-----none-----
	Hospice service	0% Coinsurance	20% Coinsurance	-----none-----
If your child needs dental or eye care	Eye exam	\$15 Copay/Visit	\$30 allowance	Coverage is limited to one Routine Eye Exam per benefit year combined In-Network Providers and Out-of-Network Providers.
	Glasses	Not Covered	Not Covered	-----none-----
	Dental check-up	Not Covered	Not Covered	-----none-----

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Routine foot care (Unless you have been diagnosed with diabetes. Consult your formal contract of coverage.)
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Infertility treatment (Artificial Insemination is limited to two procedures per lifetime combined In-Network Providers and Out-of-Network Providers.)
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide
- Private-duty nursing (Coverage is limited to 16 hours per member per benefit year combined In-Network Providers and Out-of-Network Providers.)
- Routine eye care (Adult) (Coverage is limited to one Routine Eye Exam per benefit year combined In-Network Providers and Out-of-Network Providers.)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-451-1527. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Anthem Blue Cross and Blue Shield
ATTN: Appeals
P.O. Box 27401
Richmond, VA 23279

Virginia Bureau of Insurance
1300 East Main Street
P.O. Box 1157
Richmond, VA 23218
800-522-7945

(877) 310-6560
<http://www.scc.virginia.gov/boi>
bureauofinsurance@scc.virginia.gov

Or Contact:

Department of Labor's Employee Benefits
Security Administration at
1-866-444-EBSA (3272) or
www.dol.gov/ebsa/healthreform

A consumer assistance program can help you file your appeal. Contact:
Virginia State Corporation Commission
Life & Health Division, Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo ei dooda'i, shikaa adoolwol iinizinigo t'aa diné k'éjigo, t'aa shoodí ba na'alnihi ya sidáhi bich'i naabidilkiid. Eí doo biigha daago ni ba'nija'go ho'aalagii bich'i hodiilni. Hai'daq iini'taago eiya, t'aa shoodí diné ya atáh halne'igii ní béesh bee hane'i wólta' bi'ki si'nuligii bi'kéhgo bich'i hodiilni.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers: \$7,540**
- **Plan pays: \$6,820**
- **Patient pays: \$720**

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$250
Copays	\$320
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$720

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers: \$5,400**
- **Plan pays: \$4,220**
- **Patient pays: \$1,180**

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$250
Copays	\$750
Coinsurance	\$100
Limits or exclusions	\$80
Total	\$1,180

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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